– LEGIONELLOSIS ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT –

Patient's Name: _____ (Last, First, MI.) Phone No.: ( ) _____

Address: _____ (Number, Street, Apt. No.) Patient Chart No.: _____

_____ (City, State) _____ (Zip Code) Hospital: _____

– Patient identifier information is not transmitted to CDC –

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
ATLANTA, GA 30333

2012 Legionellosis Active Bacterial Core Surveillance (ABCs) Case Report

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK

– SHADED AREAS FOR OFFICE USE ONLY –

1. STATE: (Residence of Patient) ☐☐

2. COUNTY: (Residence of Patient) _____

3. STATE I.D.: ☐☐☐☐☐☐☐

4a. HOSPITAL/LAB I.D. WHERE FIRST CULTURE IDENTIFIED OR FIRST POSITIVE TEST: ☐☐☐☐☐

4b. HOSPITAL I.D. WHERE PATIENT TREATED: ☐☐☐☐☐

5. STATE HEALTH DEPT. CASE NO. *(From CDC Legionellosis case report form for passive surveillance):* ☐☐☐☐☐☐☐☐☐

6. DATE OF SYMPTOM ONSET OF LEGIONELLOSIS: *(note this is NOT date of admission)* Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7a. WAS PATIENT HOSPITALIZED? 1 ☐ Yes 2 ☐ No

If YES, date of admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

7b. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?
1 ☐ Yes
2 ☐ No
9 ☐ Unknown

7c. Did the patient require mechanical ventilation?
1 ☐ Yes
2 ☐ No
9 ☐ Unknown

8a. Excluding the current hospitalization, was the patient hospitalized at any time in the 10 days prior to illness onset? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

If yes, Date of admission: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

Date of discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

8b. If YES, hospital I.D.: ☐☐☐☐☐

9a. Where was the patient a resident <u>in the 10 days prior to illness onset?</u> *(Check all that apply)*

1 ☐ Private residence
1 ☐ Long term care facility
1 ☐ Long term acute care facility
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Assisted Living
1 ☐ Acute care hospital
1 ☐ Other (*specify*) _____
1 ☐ Unknown

9b. If resident of a facility, what was the name of the facility? _____

10a. Was patient transferred from another hospital? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

10b. If YES, hospital I.D.: ☐☐☐☐☐

11. DATE OF BIRTH: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

12a. AGE: *(at time of onset)* ☐☐☐

12b. Is age in day/mo/yr? 1 ☐ Days 2 ☐ Mos. 3 ☐ Yrs.

13. SEX:
1 ☐ Male
2 ☐ Female

14a. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

14b. RACE: *(Check all that apply)*
1 ☐ White
1 ☐ Black
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ Unknown

15a. WEIGHT: _____lbs_____ oz **OR** _____ kg **OR** ☐ Unknown

15b. HEIGHT: _____ft _____ in **OR** _____ cm **OR** ☐ Unknown

15c. BMI: ___ ___.___ **OR** ☐ Unknown

16. TYPE OF INSURANCE: *(Check all that apply)*
1 ☐ Private
1 ☐ Medicare
1 ☐ Medicaid/state assistance program
1 ☐ Military
1 ☐ Indian Health Service (IHS)
1 ☐ Incarcerated
1 ☐ Other *(specify)* _____
1 ☐ Uninsured
1 ☐ Unknown

17. OUTCOME: 1 ☐ Survived 2 ☐ Died 9 ☐ Unknown

18. If patient died, was the initial culture or first positive test obtained from autopsy? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

19. DID THE PATIENT HAVE A CHEST CT OR CHEST X-RAY WITHIN 72 HOURS OF ADMISSION?:
1 ☐ CT 2 ☐ X-ray 3 ☐ Both 4 ☐ Neither 9 ☐ Unknown

If yes, check all that apply from the radiology report:

1 ☐ Pneumonia/bronchopneumonia
1 ☐ Consolidation
1 ☐ Lobar (NOT interstitial) infiltrate
For pneumonia/consolidation/infiltrate
1 ☐ Single lobar
1 ☐ Multiple lobar infiltrate (unilateral)
1 ☐ Multiple lobar infiltrate (bilateral)
1 ☐ Air space/alveolar density/opacity/disease
1 ☐ Atelectasis
1 ☐ Cavitation
1 ☐ Pleural effusion
1 ☐ Pneumonitis
1 ☐ Pulmonary edema
1 ☐ Interstitial infiltrate
1 ☐ Empyema
1 ☐ ARDS (acute respiratory distress syndrome)
1 ☐ Cannot rule out pneumonia
1 ☐ No evidence of pneumonia
1 ☐ Report not available
1 ☐ Other (*specify*) _____

20. WAS THE PATIENT DIAGNOSED WITH PNEUMONIA?:
1 ☐ Yes 2 ☐ No* 9 ☐ Unknown*

**If no or unknown, choose syndrome or infection type:*
1 ☐ Pontiac fever (fever and myalgia without pneumonia)
8 ☐ Extrapulmonary infection (*specify*): _____
9 ☐ Unknown

21. Did this patient have a positive flu test 10 days prior to or following a positive *Legionella* test or positive *Legionella* culture?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

22. Discharge diagnosis (check all that apply):
1 ☐ 482.84 (Legionnaires' disease)
1 ☐ 482 (other bacterial pneumonia)
1 ☐ 482.8 (pneumonia due to other specified bacteria)
1 ☐ 482.83 (other gram-negative bacteria)
1 ☐ 482.89 (pneumonia due to other specified bacteria)
1 ☐ 482.9 (bacterial pneumonia unspecified)
1 ☐ 483 (pneumonia due to other specified organism)
1 ☐ 483.8 (pneumonia due to other specified organism)
1 ☐ 484 (pneumonia in infectious diseases classified elsewhere)
1 ☐ 484.8 (pneumonia in infectious diseases classified elsewhere)
1 ☐ 485 (bronchopneumonia organism unspecified)
1 ☐ 486 (pneumonia, organism unspecified)
1 ☐ None of these listed
1 ☐ No ICD-9 codes in chart

– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

23. UNDERLYING CAUSES OR PRIOR ILLNESSES: *(Check all that apply* OR *if* NONE *or* CHART UNAVAILABLE, *check appropriate box)* 1 ☐ None 1 ☐ Unknown

1 ☐ AIDS or CD4 count <200
1 ☐ Alcohol Abuse
1 ☐ Asthma
1 ☐ Atherosclerotic Cardiovascular Disease (ASCVD)/CAD
1 ☐ Bone Marrow Transplant (BMT)
1 ☐ Cerebral Vascular Accident (CVA)/Stroke
1 ☐ Chronic Renal Insufficiency
1 ☐ Cirrhosis/Liver Failure
1 ☐ Complement Deficiency
1 ☐ Current Smoker
1 ☐ Dementia
1 ☐ Diabetes Mellitus
1 ☐ Dysphagia
1 ☐ Emphysema/COPD
1 ☐ Former Smoker
1 ☐ Heart Failure/CHF
1 ☐ HIV Infection
1 ☐ Hodgkin's Disease/Lymphoma
1 ☐ Immunoglobulin Deficiency
1 ☐ Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)
1 ☐ IVDU
1 ☐ Leukemia
1 ☐ Multiple Myeloma
1 ☐ Multiple Sclerosis
1 ☐ Nephrotic Syndrome
1 ☐ Neuromuscular Disorder
1 ☐ Obesity
1 ☐ Parkinson's Disease
1 ☐ Peripheral Neuropathy
1 ☐ Plegias/Paralysis
1 ☐ Premature Birth (specify gestational age at birth) ☐☐ (wks)
1 ☐ Renal Failure/Dialysis
1 ☐ Seizure/Seizure Disorder
1 ☐ Sickle Cell Anemia
1 ☐ Solid Organ Malignancy
1 ☐ Solid Organ Transplant
1 ☐ Splenectomy/Asplenia
1 ☐ Systemic Lupus Erythematosus (SLE)
1 ☐ Other (*specify*) _____

Legionella Test	Was this test ordered?	Date Collected	Site	Result	Species
24. Urine Antigen, EIA	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___		1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	
25. Culture	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) _____	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) _____ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ Other (*specify*) _____ 9 ☐ Unknown or not specified
26. Paired Serology, IFA or ELISA	**Acute** 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	**Acute** ___ /___ /___		**Acute** 1 ☐ Positive If yes, titer: _____ 2 ☐ Negative 9 ☐ Unknown or Indeterminate	**Acute** Species: _____ Serogroup(s): _____
	Convalescent 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	**Convalescent** ___ /___ /___		**Convalescent** 1 ☐ Positive If yes, titer: _____ 2 ☐ Negative 9 ☐ Unknown or Indeterminate	**Convalescent** Species: _____ Serogroup(s): _____
27. PCR (direct specimen only)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) _____	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ Other (*specify*) _____ 9 ☐ Unknown or not specified
28. DFA (direct fluorescence assay, direct specimen only)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) _____	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) _____ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ Other (*specify*) _____ 9 ☐ Unknown or not specified
29. IHC (immunohistochemistry)	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	___ /___ /___	1 ☐ Sputum 2 ☐ BAL/bronchial washing 3 ☐ Lung tissue 4 ☐ Pleural fluid 5 ☐ Blood 8 ☐ Other (*specify*) _____	1 ☐ Positive 2 ☐ Negative 9 ☐ Unknown or Indeterminate	1 ☐ *L. pneumophila* If yes, list serogroup: 1 ☐ serogroup 1 8 ☐ Other (*specify*) _____ 9 ☐ Unknown 2 ☐ *L.* species (non-*pneumophila*) 8 ☐ Other (*specify*) _____ 9 ☐ Unknown or not specified

30. COMMENTS: _____

_____

– SURVEILLANCE OFFICE USE ONLY –

31. Was case first identified through audit?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

32. Was this case also identified through routine passive notifiable disease surveillance?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

33. CRF Status:
1 ☐ Complete
2 ☐ Incomplete
3 ☐ Edited & Correct
4 ☐ Chart unavailable after 3 requests

34. Does this case have recurrent disease?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
If yes, previous (1st) state ID: ☐☐☐☐☐☐☐

35. Case status:
1 ☐ Confirmed
2 ☐ Suspect

36. Date reported to EIP site:
Mo. ☐☐ Day ☐☐
Year ☐☐☐☐

37. Initials of S.O.: _____

Submitted By: _____ Phone No. : ( )_____ Date:____ /____ /_____

Physician's Name: _____ Phone No. : ( )_____